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GRADUATES FROM DUAL QUALIFICATION COURSES, REGISTERED NURSE AND HEALTH VISITOR: A CAREER HISTORY STUDY.

ABSTRACT

Background

Educationalists and managers internationally are challenged to find ways of preparing, recruiting early in their careers, and retaining nurses into public health roles in primary care. Public health nursing qualifications are post-initial nurse registration in the United Kingdom as in some other countries. In the mid twentieth century there were a number of innovative programmes of dual qualification: registered nurse and health visitor (the United Kingdom term for public health nurse).

Objective

To investigate the career histories of graduates from courses integrating both nursing and health visitor qualifications.

Design

An observational ,survey study.

Setting

The United Kingdom.

Participants

A purposive sample of graduates from integrated registered nurse and health visitor programmes, 1959-1995, from one University.

Methods

Self completed, anonymous, survey sent to graduates, with contact details known to the University and through snowballing techniques, in 2011.

Findings

Forty five women (56%), graduates in all four decades, returned the survey. A significant majority (82%) had taken up health visitor posts on completing the course. Over their careers, 42% of all jobs held were as health visitors. Only four never worked in a post that required a health visiting qualification. Most had undertaken paid work throughout their careers that focused on aspects of public health, often linked to child, maternal and/or family wellbeing. Many held teaching/lecturing and management posts at some point in their career. Those holding management posts were more likely to report leaving them as a result of organisational re-structuring or redundancy than those in non-management posts.

Conclusions

Courses that prepare students to be both nurses and health visitors result in a majority of graduates who take up posts as health visitors on qualification and subsequently. Nurse education planners may find this evidence of value in determining ways of providing a future workforce for public health nursing.

Key words

Health Visitor Education, Nurse Education, Public Health Nursing Education, Public Health Workforce

INTRODUCTION

The majority of qualified nurses are employed in hospital and care home settings but the demand for nurses to work in public health and primary care settings is increasing as countries invest in primary health care and chronic disease management systems (World Health Organisation [WHO] 2008, 2009). The recruitment of nurses into primary care and public health settings is a major challenge in many countries (Rosenblatt et al 2006, Daviaud & Chopra M 2008), particularly in rural and isolated communities (Goodyear-Smith & Janes 2005, Minore et al 2005). The challenges in each country deriving from a mixture of a) increased demand for nurses, often in the absence or shortage of other professionals, b) the perceived greater attraction of nursing within hospital settings, c) the difficulty of retaining nurses, like other professionals, in rural areas as opposed to urban areas and d) the larger numbers in this nursing workforce in the age group close to retirement. Many undergraduate nurse curriculums have increased components of learning about and within public health and primary care settings (Nursing & Midwifery Council 2004, American Association of Colleges of Nursing 2008). However, there is little evidence to support the belief that greater pre-registration learning in primary care and community settings will attract more nurses to work long term in that arena. This paper reports on a study that adds to that evidence base through an investigation into the careers of nurses who graduated from innovative courses with dual qualifications of state registered nurse and state registered health visitor (the UK public health nurse qualification) between 1959 and 1995. These were graduates from one University, which was one of several (Owens 1977) that provided such courses.

BACKGROUND

Internationally, there are different routes for the preparation of public health nurses but most view it as a post-initial nurse qualifying course. The term 'public health nurse' is not used "consistently in the literature or in practice" (Edgecombe 2001p7) and is often used interchangeably with others such as community nurse and health visitor (Kendall 2008). In many countries the role of public health nurse is one that encompasses both care of the sick, chronically ill and dying within the home and also the promotion of the health of the community, often particularly focused mothers and children. These roles may be known as public health nurses, for example in Eire (Nic Philibin et al. 2010) or they may have other titles derived from a history of district or visiting nurses, for example some states of the United States of America (Grumbach et al. 2004). In other countries, for example New Zealand (Royal New Zealand Plunket Society inc 2011) and Hong Kong (Shui 1998), these functions are separated into two different nursing roles and services. In the United Kingdom (UK), from the mid-nineteenth century onwards, two distinct roles with distinct educational preparation developed: the health visitor as the public health specialist focused mainly on maternal and child health and the district nurse as the home visiting nurse who also provided health education (Baly 1995). Although it should be noted that many areas, individual nurses were employed to undertake both roles, known as dual role or when midwifery was added triple duty nurses (Drennan and Williams 2001).

The UK has over a hundred years of experience in developing the provision of nursing in community and primary care settings (Baly 1995). Despite this, there have seen repeated concerns as to whether there were and would be sufficient nurses for these settings (Lords Hansard 2003), particularly set against the large numbers close to retirement ages (Storey et al 2009). Most recently, a national shortage of public health nurse specialists, known as health visitors, has been acknowledged in England (Deputy Chief Executive and Chief

Nursing Officer 2011). However, the nursing leadership in the National Health Service (NHS) have been considering these issues for some time, against a back drop of a well developed human resources strategy for the NHS (Department of Health 2004). Exploration of flexible entry routes for nurses, including newly qualified, into primary and community nursing (Drennan et al 1998) was reinforced in the guidance issued by the Chief Nurses of the four UK nations on modernising nursing careers which placed emphasis on pre-registration preparation for working in primary care and public health (Department of Health 2006).

Combined nurse and health visiting courses

Addressing community nurse and public health nurse shortages is not new. The decades after the second world war saw similar problems which were addressed by both more training centres and innovation in programmes which combined initial nurse training with health visitor training (Ministry of Health 1956, Owens 1977). The University of Southampton was one centre that offered this combined (known as integrated) course from 1957 which was validated with a social science degree from 1971 (O'Connell 1978). Over the years national changes in the regulations for courses of nursing and health visiting meant the original shape of the course changed (Table 1), as did the participating schools of nursing, until finally the national nursing regulatory body's support for only Bachelor of Nursing degrees and diplomas in nursing brought the demise of the final iteration of the integrated course.

Two surveys in the early eighties suggested that the graduates from the integrated courses with degrees remained in nursing (Royal College of Nursing [RCN] 1985, and predominantly health visiting (Martin and Gastrell 1982). However, there is no evidence as to the impact of such courses over a life time.

Table 1 Integrated Courses at the University of Southampton 1957-1990

Years of intake to the course	Professional qualifications	Degree	Participating school of nursing	Numbers graduating
1957-1968	State registered nurse Health Visitor Certificate	None	St. Thomas' Hospital London School of Nursing	68
1969-1971	State registered nurse Registered Health visitor	BSc.(Hons) Sociology & Social Administration (Health visiting option)	St. Thomas' Hospital London School of Nursing	1
1972- 1977	State registered nurse Registered Health visitor	BSc (Hons) Sociology and Social Administration,	St. Thomas' Hospital London School of Nursing	31
1978- 1983	No programme	-	-	0
1984-1988-	State registered nurse Registered Health visitor	BSc (Hons) Sociology & Social Policy	Portsmouth District School of Nursing	24
1989 -1990	State registered nurse Registered Health visitor	BSc (Hons) Sociology & Social Policy	Southampton School of Nursing	10
			Total	134

The majority of those entering general nursing training are women. Women's participation in the labour market (i.e. paid work) over time is known to be influenced by social, economic and institutional factors (Hakim 1996). Hakim (2002) has also theorised that preferences of lifestyle are important in societies which have conditions that allow women choices regarding paid employment. She posits a typology of three groups; those who are home-centred, those work centred and those who are adaptive (i.e. prefer to combine family and employment with

no fixed priority). She further argues that qualifications are obtained only as cultural capital by those who are home centred, as significant investments in the future by the work centred, and with the intention of working by the adaptive who are the majority group (Hakim 2001). This would suggest that the majority who obtained these qualifications would use them in paid employment over time. Further, Dingwall (1977), in a seminal ethnographic study of health visitor education in the seventies, argued that there was a strong element of socialisation which produced a group identity. This theorising would also suggest that people graduating from such courses would retain that identity and occupational role for many years.

There is currently no evidence to inform educators, service managers and commissioners of education courses as to the consequences on careers when qualifying courses emphasise experience in community health services and primary care. Many of the graduates of these integrated courses are now approaching or beyond retirement age. This paper reports on a study which investigated the career histories of graduates of these courses and the extent to which they were employed in public health and community health services. It addressed the questions:

Do graduates of dual qualification courses initially and subsequently work in the field of health visiting or associated fields?

What influences their decisions to take up or leave positions, in the initial post qualifying period and subsequently?

METHOD

The research design drew on the interpretive tradition (Crotty 1998), seeking the participants accounts of their lives since graduating from the integrated courses. While methods such as

semi-structured interviews for life narratives (Leibic et al 1998) were considered the resources required were beyond that of the research team and a self report questionnaire with opportunities for free text was chosen as the data collection tool. The questions were informed by the literature and the purpose of the study. Details of education, qualifications, numbers and types of paid posts, time periods as a family maker/carer were requested. Reasons for taking a post and leaving it were also required. Questions required factual numerical responses and also gave space for free text explanations. Due to the potential small size of the sample group, piloting was not undertaken with any of them but a peer review process allowed for refinement of the format and wording of some questions.

The participants were purposively selected as those who had graduated from an 'integrated' nursing and health visiting qualification course and for whom there were contact details through alumni communications and events, to send the questionnaire. The invitation to participate and questionnaire was sent in 2011 by post or email depending on available contact details. The questionnaire required no identifying information such as name or contact details and those returned by email went to an administrative staff member who removed the electronic completed questionnaire from the email and only passed that on to the research team, maintaining anonymity. A second invitation was sent out six weeks after the first. All participants were invited to forward the invitation to any other graduates of their course who they were still in touch with.

From the returned questionnaires, the factual data was coded and recorded electronically. Data checking and descriptive statistical analysis took place in Microsoft Excel and Stata software. Confidence intervals for proportions were assessed by the exact binomial distribution and Fisher's exact test with Bonferroni correction was used to compare proportions between stages in participants' careers; where no p-value is given in the results, the difference was not significant. The free text was collated into word documents, analysed thematically by two researchers independently and then compared (Silverman 2006). Any differences in interpretation were resolved through discussion.

The study received a favourable ethical review from the University of Southampton, Faculty of Health Sciences Ethics Committee.

RESULTS

Invitations and questionnaires were sent out to 86 people. Of these 6 were returned as deceased or not known at that address. Forty five people returned completed questionnaires; giving a response rate of 56%. All respondents were women. Graduates from all decades of enrolment responded (Table 2) with nearly two thirds also graduating with degrees.

Table 2 Year of Enrolment

Year enrolled in the course	Number of respondents (%)
1955-1959	10 (22)
1960-1970	9 (20)
1971-1980	14(32)
1986-1990	12 (26)
Total	45 (100)

While the survey did not specifically ask why this integrated course had been chosen some respondents offered some information indicating that the position of health visitor was one they were interested in on entering the course.

“At 17 yrs old a friend told me about health visiting and I became interested and followed this up with the School Career Advisor as I wanted to be a health visitor”.

(Enrolled 1971 – 1975)

Eighty two per cent (36/44) of the respondents took a first work position after completing the course as a health visitor. Inferring from this sample to graduates of similar courses over the

years, the 95% confidence interval for the percentage working as health visitors on graduation is 67%-92%, clearly the majority of graduates. While 43% reported their choice of post was a natural progression from the course, others reported motivation that reflected diversity such as the post was chosen for convenient hours or for the opportunity to travel (e.g. overseas health visiting posts in non-governmental organisations). The length of time in the first posts ranged from less than a year to 20 years with a mode of 2 years.

Of the 37 reporting second paid posts, 18 (49 %) were also health visitor posts. A greater diversity in posts were now apparent with 8 in nursing posts (2 in the family planning speciality), 5 in teaching/lecturing posts and 3 in midwifery posts , and 3 were in other types of posts. The presence of other family responsibilities now appear with six reporting part time employment and three reporting themselves as full time family carers. One respondent offered an explanation from her perspective of the move to a different type of role but still within the arena of maternal and child health.

“At age 23 years I and my fellow health visitors all felt rather young and short on life experience to be an expert in community and family life affairs. Some of us went on to do midwifery or to gain other experience.” (Enrolled 1960-1964).

The respondents between them reported 252 paid posts over their lives to date. Analysis of these by type identified that overall 42% were health visiting posts. Three people reported having only ever been employed as health visitors and a further 25 (56%) had held 2 or more health visitor posts. Some of these commented on the changes they had seen in health visiting over their working careers;

“The job of health visiting has changed so much over the last 15 years I have been doing it. I feel devalued and de-skilled. The drastic number in reduction of health visitors leaves me very little time and ability to do health promotion work. The vast majority of my work consists of new birth visits and child protection work. The course I studied for 5 years bears no resemblance to the job I do now”. (Enrolled 1986-1990)

Four reported never having held a health visiting post. One of these only worked in the field of midwifery (and midwifery lecturer), one only as a counsellor, and two only as nurses (including nursing management posts). One respondent reflected how her health visitor training had influenced her nursing practice in a hospital

“I believe I would not have been as good a ward sister without health visitor training. All those visits to peoples’ homes and the gypsies in the New Forest were absolutely invaluable, I never allowed consultants to send a patient home on a Friday afternoon.” (Enrolled 1955-1959)

While one respondent commented that she had found it was difficult to move from working in health visiting to another clinical area and progress her career, there was great variety in the posts and careers that were reported. The majority of paid posts, which the respondents reported over their life course, were linked in some way to population health and well being, particularly of women, children and families. Those reporting posts in Local Authorities rather than health services described these as leadership roles in the provision for children and families, likewise those in counselling roles and in the voluntary (non-governmental) sector. Those with teaching or lecturing roles were in health studies; varying as to whether they were educating nurses and health visitors or other groups such as nursery nurses, who provide care for children in a variety of settings in the UK and increasingly in health visiting teams (Drennan and Davies 2008).

Nineteen (42%) of the respondents had held teaching or lecturing posts in their careers. Eleven (25%) of the respondents had held a management position at some point in their careers. Two had held both management and teaching or lecturing posts. Twelve (25%) had worked as nurses at some point in their careers. A number reported more than one post at a given time period e.g. midwife and also a midwifery tutor.

When considering the length of time of posts over their careers, we had to set aside data from four respondents who had double-counted the lengths of posts, perhaps reflecting part-time working, perhaps in error, but without information enabling us to interpret it. The posts that the respondents had held over their careers added to a total of 1155 person-years, 37% of which was as a health visitor, 19% as a teacher / lecturer, 11% manager / director, 9% nurse, 7% advisor / co-ordinator. All other job types contributed less than 5%. Over all the careers, 13% of the person-years were spent in part-time posts: 31 part-time posts were reported from 18 nurses. These were spread over quite a long time in the careers: 4 happened within 5 years of graduation, 8 between 5-10 years, 9 between 10-15 years, 6 within 15-20 years, and 4 thereafter.

The respondents reported the number of paid posts they had held as between 2 and 13. We defined “earlier career” as up to 10.5 working years post-graduation, and “later career” after this point, because this split the numbers of posts roughly in half. The types of job differed in some ways over time:

- Health visitor posts made up 63% of the person-years in earlier careers and 30% in later careers.
- Nursing posts made up 9% in both earlier and later careers
- Teaching / lecturing posts made up 7% earlier and 23% later
- Manager / director posts made up 4% earlier and 14% later
- Midwifery posts made up 5% earlier and 2% later
- Part-time posts made up 9% earlier and 14% later

There was no clear trend in the length of time of a post over the career, but there were some evident differences in the motivations for choosing or leaving the job. Earlier career posts were more often chosen because of “natural progression from the course” (15% vs 1%,

statistically significant $p < 0.001$), “money” (6% vs 3%) or “to gain experience” (12% vs 5%). Later career posts were more often chosen for “promotion” (5% vs 18%, statistically significant $p = 0.003$), because they are “interesting” (7% vs 11%) or because of “study” (1% vs 4%). The most common reason given was “convenient hours and/or place”, which was given for 36% of earlier posts and also of later posts.

In terms of reasons for leaving, earlier career posts were left more often because the person “moved” (31% vs 7%, statistically significant $p < 0.001$) or because of “children / family / marriage” (28% vs 7%, statistically significant $p < 0.001$). Later career posts were more often because of “closed department / redundancy / end of contract / retirement” (12% vs 29%, statistically significant $p = 0.002$), the participant “changed type of job” (8% vs 16%), “study” (3% vs 8%) and “ill health” (1% vs 8%). Some of the participants reported a series of posts all left because of “closed department / redundancy / end of contract / retirement” so this is evidently not an artefact of retirement at the end of their careers. Among managerial posts, 48% ended for this reason, compared to 16% in non-managerial posts (statistically significant, $p = 0.001$).

A high proportion had gone on to further study. Most of those who graduated with only the professional qualifications had gone on to gain degrees. Nineteen (42%) reported the achievement of further nursing or midwifery qualifications, while fifteen (33%) reported attaining masters levels qualifications and 4 had doctorates. Some of those graduating with the social science degrees reported that their degrees did not fit with the expectations of the UK nursing profession.

“A lack of openness to people who have degrees that are non nursing. Nurses seem to favour those who have followed a mainstream and maybe quite narrow career path more focussed on nursing topics. Having a degree in social science and an MSc in mothers’ and child health has not been seen as nursing”. (Enrolled 1976-1980)

Fourteen people (31%) reported time periods as family carers: this ranged from two to 14 years in length. In part this may reflect prevailing social norms of different decades as one respondent pointed out

“ When I married in 1964 most women gave up their careers, this is different than today where finances make it necessary for women to continue work and husbands play a more active role in raising family” . (Enrolled 1955-1959)

One respondent commented that once she had left health visiting to have a family there had never been any encouragement from the local health visiting management to return in a part-time capacity. Nineteen (42%) reported part-time paid employment at some point in their carers; seventeen having subsequent full time paid employment.

Many of the respondents reported their broader contribution to civic life and the public health in roles such as volunteer advisors at Citizen Advice Bureaus, school governors, magistrates and trustees of charities.

“I have always been an active CPHVA (Community Practitioner and Health Visitor Association) member, speaking for health visitors and role of the profession and a nurse member on a PCT (Primary Care Trust) Executive Board. I am now a volunteer with a toy library and a trustee of various health related organisations” . (Enrolled 1955-1959).

DISCUSSION

This survey of the work careers of 45 women, graduating with both health visiting and nursing qualifications between 1959 and 1995, demonstrates that the majority worked in health visiting in their first job after graduating. A small number worked only in health visitor posts but 42% of all the posts held by this group over their work careers were in health visiting. Only four never worked in a post that required a health visiting qualification. While

many had periods of family care only activity and many worked part-time at various points in their careers, most have undertaken paid work throughout their work careers (to date) that focused on aspects of public health, child, maternal and/or family wellbeing. Those civic activities described by respondents also fall broadly in that category. A large number moved to teaching/lecturing and management posts at some point in their career, though they did not necessarily stay in those posts. Those holding management posts were more likely to report leaving them as a result of organisational re-structuring or redundancy than those in non-management posts.

To our knowledge, this is the first time that the impact of an educational innovation aimed at encouraging nurses earlier in their careers to work in the field of health visiting and public health has been described from the longitudinal perspective of a working career. Early follow up of graduates from this ((Martin and Gastrell 1982) and other similar courses (Marsh 1976, Royal College of Nursing 1985) suggested most went into health visiting in their first post. While there have been studies following up graduates of UK nursing only degree programmes for longer periods (Ring 2002), there has been no other follow up of graduates from any programmes offering nursing and health visiting.

Our study suggests that those in programmes that combine nursing and health visiting remain orientated to, at the very least, public health and a sizeable proportion to specifically the work of health visitors over their working careers. This could be further tested through follow up graduates of the other dual qualification courses referred to by Owen (1977). It could be also be tested in international comparisons for example of graduates of Baccalaureate nursing programmes in the USA which were introduced with a strong public health component in the sixties (Levin et al 2008), and more recently in Canada (Chalmers et al 1998). This could also give an opportunity for nurse educators to compare and contrast public health elements of curricula.

Individuals make comment about their relative young age on qualifying as a health visitor however investigations in the eighties found no evidence that the age of qualifying affected the health visiting practice negatively (McClymont 1980).

The findings suggest that the majority of graduates were of Hakim's (2002) adaptive type in their approach to paid employment and used their qualifications with the intention of working, although it is interesting to note how many of them continued to gain qualifications. In this study however, the impact of health service reorganisation for those managerial posts appears greater than the impact of life style preference on working. For those in managerial posts a significantly greater proportion of posts were ended due to departmental closure, redundancy, fixed term contracts and retirement in the latter half of the careers. In these posts, individuals were three times more likely to leave for these reasons than in other posts. To our knowledge this has not been reported before in nursing career studies and warrants further investigation to understand whether this has been unusual or is a more pervasive experience of nurse managers.

The study findings indicate that while many work in health visiting posts throughout their career many do not. This suggests that the socialisation into health visiting that Dingwall (1977) identified may not last over longer period of time. This requires further investigation with these and other cohorts of graduates from health visiting courses as to their view of their professional identity.

The study has limitations: only contact details were obtained for approximately two thirds of those who graduated (although it is not known how many of those are deceased). Of those, replies were received from only 56%. While this response rate is just above the average return rate for academic studies (Baruch 1999) there is no way of knowing if these respondents were representative in their careers of either the total or even those for whom contact details were known.

CONCLUSIONS

This study suggests that courses that prepare students to be both nurses and health visitors result in a majority of graduates who take up posts in health visiting on qualification, and many continue in health visiting posts over their working careers. More broadly it would seem these types of course give the graduates a public health orientation evident both in careers they pursue in associated fields but also in their contribution to civic life. Those responsible for policy in nurse education and looking to future provision of public health nurses and those likely to work outside acute hospital settings would do well to consider the legacy of the pioneers of community and public health nursing education in the U.K.

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